Latisse®
(bimatoprost ophthalmic solution) 0.03%

Exclusively for members of Brilliant DISTINCTIONS® PROGRAM

Buy one 5-mL kit…
Get one 3-mL kit FREE!

Ask your doctor if LATISSE® is right for you

Terms of this offer:

Offer good with retail purchase of $105 or more for the 5-mL kit. Limit one free 3-mL kit per person or two free 3-mL kits per household, per year. No substitutions permitted. Form is not valid with any other program, discount, or incentive involving LATISSE®. Claims for the free LATISSE® 3-mL kit or any related consultation or treatment may not be submitted for reimbursement to any public (eg, Medicare, Medicaid) or any private (eg, insurance company) payer or other person for reimbursement, in whole or in part. This form is void outside of the United States and anywhere else where prohibited, taxed, or otherwise restricted by law. This form is not in any way conditioned on any past or future purchases of any Allergan product or service. Past or future use is not a requirement for the use of this form. Allergan reserves the right to rescind, revoke, amend, or cancel this offer at any time without notice.

Please contact your medical doctor about additional LATISSE® refills.

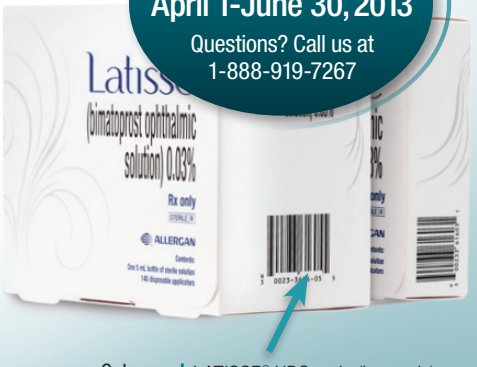
*Please note: Prescriber's signatures are allowed based on the prescribing authority in your state and the medical degree of your doctor.

If there are any questions about the information you provide, you will receive a follow-up phone call at the number you provide below.

Here's how it works:

1. **Make an appointment with your doctor*** to see if LATISSE® is right for you. **LATISSE® is available by prescription only.**
2. **Fill in** the form below. You provide your patient information and your doctor writes in the prescription and practice information. Be sure to write legibly.
3. **Buy your 5-mL kit**, either at your doctor's office or at the pharmacy. Make sure to keep your proof of purchase—the original receipt and the UPC code (bar code) from the LATISSE® 5-mL box.
4. **Mail in** the completed form, original receipt, and UPC code (bar code) to:
   LATISSE® BOGO Program, PO Box 416, Sea Girt, NJ 08750
   Be sure to keep a copy for your records.
   Completed form and proof of purchase must be received by July 31, 2013.
5. **Get your FREE 3-mL kit in the mail.** Please allow 10 to 14 days from the time your form (with proof of purchase) is received for delivery of your free 3-mL kit.

Limited time only
While supplies last
April 1-June 30, 2013
Questions? Call us at 1-888-919-7267



Only one kit per UPC code | LATISSE® UPC code (bar code), original receipt, and completed form must be submitted together.

PATIENT INFORMATION

Please print:

First Name _____ Last Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Date of Birth _____

Patient Allergies _____ ❑ N/A

Patient Health Conditions _____

Email Address **(required to redeem this offer‡):**

_____

‡Providing your email address allows for tracking information to be sent to you regarding your product shipment.

❑ Yes, I would like to receive my 1 FREE LATISSE® (bimatoprost ophthalmic solution) 0.03% kit.

❑ Yes, I would like to also receive emails with special offers, tips, and other information from Allergan about LATISSE® (bimatoprost ophthalmic solution) 0.03%.

Authorization for the use and disclosure of my protected health information:

I hereby acknowledge that the information I have provided above will be transmitted via mail to PSKW/DSI for the purposes of processing this offer. PSKW/DSI will forward the information to a pharmacy, which will be responsible for dispensing LATISSE® directly to me. The information I have provided above will also be provided to Allergan by PSKW/DSI. My email address will be shared in accordance with the requirements to opt in and redeem this offer. My other information (name, address, city, state, zip, phone number, and date of birth) may be shared. I understand that the information provided to Allergan may be used for, but not limited to, purposes of assisting Allergan in understanding how to better market LATISSE®. This authorization will expire upon the expiration date of this form and may be revoked by me at any time by notifying Allergan, Inc., in writing at: Allergan, Inc., PO Box 19534, Irvine, CA 92623, USA. I further understand that because Allergan is not covered by the federal privacy regulations, after my information is disclosed to Allergan, it will no longer be protected under federal law and could be subject to redisclosure. The information will, however, be treated as confidential by Allergan and will be protected by its privacy policy. I understand that I may refuse to give this authorization and that the doctor's office or pharmacy may not condition my treatment, payment, enrollment, eligibility for benefits, or receipts of any medications or pharmaceuticals on whether I provide this authorization.

All fields are required in order for prescription to be valid.
You may also attach a prescription.

℞ LATISSE® (bimatoprost ophthalmic solution) 0.03%
Use as directed.

Issue Date _____

Prescriber's State License No. _____

Prescriber's Signature (no stamps) _____

Prescriber's§ First Name _____ Last Name _____

Practice Name (if applicable) _____

Practice Address _____

City _____ State _____ Zip _____

Practice Phone _____

§Prescriber = MD or DO in any state in the United States, or OD (optometrist) in any state in the United States except CA or MD.

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